IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
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September 9, 2010

Steve Silberberger, Administrator
Seven Oaks Community Homes - Pinnacle
3940 West 5th Avenue #c
Post Falls, ID 83854

RE: Seven Oaks Community Homes - Pinnacle, Provider #13G076

Dear Mr. Silberberger:

This is to advise you of the findings of the Medicaid/Licensure survey of Seven Oaks Community Homes - Pinnacle, which was conducted on September 2, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner**:

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of

being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions, which require construction, competitive bidding or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **September 22, 2010,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in the State Informal Dispute Resolution (IDR) Process which can be found on the Internet at:

www.icfmr.dhw.idaho.gov

Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

This request must be received by September 22, 2010. If a request for informal dispute resolution is received after September 22, 2010, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

Jim Troutfetter
Health Facility Surveyor
Non-Long Term Care

Nicole Wisenor
Co-Supervisor
Non-Long Term Care

JT/srp
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G076	A. BUILDING _____ B. WING _____	09/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN OAKS COMMUNITY HOMES - PINNACLE	3908 NORTH PINNACLE LANE POST FALLS, ID 83854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies was cited during the annual recertification survey. The survey was conducted by: Jim Troutfetter, QMRP, Team Leader Barbara Dern, QMRP Common abbreviations/symbols used in this report are: HRC - Human Rights Committee IPP - Individual Program Plan QMRP - Qualified Mental Retardation Professional	W 000	RECEIVED OCT 04 2010 FACILITY STANDARDS	
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews, it was determined the facility failed to ensure individuals' rights were allowed and encouraged for 3 of 5 individuals (Individuals #2, #3, and #5) residing in the facility. This resulted in a lack of protection of individuals' rights through prior approvals on restrictive interventions. The findings include: 1. Individual #1's IPP, dated 8/31/09, documented a 14 year old female diagnosed with severe mental retardation and a seizure disorder.	W 125	**W125** It is the facility's intent to ensure the rights of all individuals in the facility and to facilitate and encourage individuals to exercise these rights. The facility will carefully review all proposed restrictive procedures and ensure that all guardians are contacted and have the opportunity to give or deny consent prior to the implementation of any restrictive procedures Completion Date: October 1, 2010 By Whom: QMRP and Administrator	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Claude Ricket	Program Director	9-30-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 125	Continued From page 1 During observations at the facility on 8/30/10 from 4:10 - 4:57 p.m. and 5:20 - 6:15 p.m., and on 8/31/10 from 5:55 - 7:20 a.m., 9:37 - 10:25 a.m., and 6:35 - 6:45 p.m., and an environmental review on 9/1/10 from 12:50 - 1:05 p.m. it was noted that there was a sliding lock on the top inside of the front door of the facility. The lock was not within reach of the individuals residing in the facility. When asked, a staff member that was present during the observation on 8/31/10 from 5:55 - 7:20 a.m., stated the lock was placed on the front door due to Individual #1 leaving the facility three times without staff knowledge. Additionally, the QMRP stated during an interview on 9/2/10 from 8:55 - 9:20 a.m., the lock was installed on the door on 8/25/10 and the facility began the process of obtaining verbal consents. Individual #1's record included an HRC and verbal guardian consent, dated 8/25/10, which included the use of door locks. However, a review of Individual #2, #3, and #5's records showed HRC and guardian consents for the door lock were not present prior to implementation. When asked, the QMRP stated during an interview on 9/2/10 from 8:55 - 9:20 a.m., not all guardians had consented to the lock prior to the installation and Individual #3's guardian had not given verbal consent until 8/30/10. The facility failed to ensure Individuals #2, #3, and #5's rights were protected through prior approvals on restrictive interventions.	W 125		
W 278	483.450(b)(1)(iii) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR	W 278		

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W 278	Continued From page 2 Procedures that govern the management of inappropriate client behavior must insure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews, it was determined the facility failed to ensure individuals records included evidence of least restrictive or more positive techniques being utilized prior to the use of more restrictive techniques to manage behavior for 1 of 2 individuals (Individual #1) whose restrictive interventions were reviewed. This resulted in the potential for an individual to be subjected to restrictive interventions unnecessarily. The findings include: 1. Individual #1's IPP, dated 8/31/09, documented a 14 year old female diagnosed with severe mental retardation and a seizure disorder. During observations at the facility on 8/30/10 from 4:10 - 4:57 p.m. and 5:20 - 6:15 p.m., and on 8/31/10 from 5:55 - 7:20 a.m., 9:37 - 10:25 a.m., and 6:35 - 6:45 p.m., and an environmental review on 9/1/10 from 12:50 - 1:05 p.m. it was noted that there was a sliding lock on the top inside of the front door of the facility. The lock was not within reach of the individuals residing in the facility. When asked, a staff member that was present during the observation on 8/31/10 from 5:55 -	W 278	**W278** It is the facility's intent to ensure that individual records accurately reflect intervention techniques and strategies that are used to assist individuals to develop skills and establish and maintain appropriate and functional behaviors. The facility will review all records to ensure that each record reflects (as appropriate) less restrictive alternatives that have been used and their effectiveness (or lack thereof) prior to the implementation of more restrictive procedures. Completion Date: October 1, 2010 By Whom: QMRP and Administrator	

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W 278	Continued From page 3 7:20 a.m., stated the lock was placed on the front door due to Individual #1 leaving the facility three times without staff knowledge. However, Individual #1's record did not contain documentation of less restrictive or more positive techniques being utilized prior to implementation of the door lock. When asked, the QMRP stated during an interview on 9/1/10 from 2:55 - 3:20 p.m., less restrictive programs had not been tried prior to implementing the door lock. The facility failed to ensure there was sufficient evidence of less restrictive alternatives that were systematically tried and proven ineffective prior to implementing a door lock.	W 278		
W 289	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure techniques used to manage inappropriate behavior were incorporated into the program plans for 1 of 2 individuals (Individual #1) whose behavior plans were reviewed. This resulted in interventions being used that were not included in the individual's behavior management program. The findings include:	W 289	**W289** It is the facility's intent to ensure that all procedures being used to assist individuals to develop and maintain appropriate and functional behavior as well as reduce inappropriate behavior are included in each persons program plans. The facility will review all program plans for each person to all techniques and procedures are consistently included in each person's program plans. Completion Date: October 1, 2010 By Whom: QMRP and Administrator	

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W 289	Continued From page 4 1. Individual #1's IPP, dated 8/31/09, documented a 14 year old female diagnosed with severe mental retardation and a seizure disorder. During observations at the facility on 8/30/10 from 4:10 - 4:57 p.m. and 5:20 - 6:15 p.m., and on 8/31/10 from 5:55 - 7:20 a.m., 9:37 - 10:25 a.m., and 6:35 - 6:45 p.m., and an environmental review on 9/1/10 from 12:50 - 1:05 p.m. it was noted that there was a sliding lock on the top inside of the front door of the facility. The lock was not within reach of the individuals residing in the facility. When asked, a staff member that was present during the observation on 8/31/10 from 5:55 - 7:20 a.m., stated the lock was placed on the front door due to Individual #1 leaving the facility three times without staff knowledge. However, Individual #1's record did not contain a Plan Sheet related to elopement. When asked, the QMRP stated during an interview on 9/1/10 from 2:55 - 3:20 p.m., Individual #1's plan was being revised and had not been implemented. Further, the QMRP stated, the lock had been put into place prior to a plan being developed. The facility failed to ensure techniques used to manage inappropriate behavior were incorporated into Individual #1's program plan.	W 289		

Bureau of Facility Standards

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MM167	16.03.11.075.07 Exercise of Rights Exercise of Rights. Each resident admitted to the facility must be encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end can voice grievances and recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal. This Rule is not met as evidenced by: Refer to W125.	MM167	**MM167** Please refer to W125	
MM191	16.03.11.075.09(c) Last Resort Physical restraints must not be used to limit resident mobility for the convenience of staff, and must comply with life safety requirements. If a resident's behavior is such that it will result in injury to himself or others and any form of physical restraint is utilized, it must be in conjunction with a treatment procedure designed to modify the behavioral problems for which the patient is restrained and, as a last resort, after failure of attempted therapy. This Rule is not met as evidenced by: Refer to W278.	MM191	**MM191** Please refer to W278	
MM197	16.03.11.075.10(d) Written Plans Is described in written plans that are kept on file in the facility; and This Rule is not met as evidenced by: Refer to W289.	MM197	**MM197** Please refer to W289	

Bureau of Facility Standards

Claude Richet — Program Director — 9-30-10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE